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INSIDE

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Health system tackles medical necessity ogre, brings 10 hospitals into the fold

Getting medical records staff on board is crucial

How a hospital copes with "medical necessity" — two of the most ominous words to become part of the industry buzz in recent years — has everything to do with the health of its bottom line. With that in mind, the 10-hospital Baptist Health System (BHS), based in Birmingham, AL, is entering the third phase of a program focused on ensuring that the procedures and tests ordered by its physicians meet the Baltimore-based Health Care Financing Administration's (HCFA) medical necessity guidelines.

In February 1999, BHS began checking for medical necessity at the point of scheduling at one of its facilities and attempting to reconcile non-matching diagnoses and procedures, says **Becky Miller,** director for compliance, patient business services. By August, that process was in place at all 10 hospitals.

To make it easier for physicians to cooperate in the effort, BHS distributed about 1,500 copies of the guidebook *Code First: Medicare Medical Necessity Reference*. Developed at one of its own hospitals, the book identifies the procedure / diagnosis matches required for reimbursement. **(See related story, p. 123.)**

Before that, in phase one of the program, the health system identified procedures that failed medical necessity — using software from Omega Systems Inc. in Tampa, FL — and wrote them off, Miller notes. "We knew we shouldn't bill for them."

In phase three, BHS is expanding its program by checking medical necessity at the point of registration for unscheduled patients, she says, a process that originally was expected to be under way by late September. Additionally, it requires waivers signed in advance for lab tests that do not meet medical necessity, Miller says.

Anecdotal evidence indicates the focus on medical necessity is paying off, she adds. "We are seeing physicians change their mind and not do a test, or come back with a diagnosis that supports a procedure, and [the

schedulers] will jump up and down. They'll say, 'So-and-so just saved us $600,' or 'That saved us $1,000. We don't have to write it off.'"

Measuring any overall positive result is difficult, however, with a target that is constantly moving, Miller points out. "Every month, Medicare adds something new [to the list of procedures that must meet medical necessity]. Things don't stabilize enough to know the progress you've made."

At present, she estimates, there are about 400 procedures for which HCFA requires providers to show medical necessity, "ranging from little labs to surgeries and MRIs."

How BHS does it

When a physician's office calls to schedule a procedure at BHS, schedulers identify the patient and the test being performed, then check a list to determine the assigned CPT-4 code, explains Miller. They ask callers for a diagnosis, encouraging them to specify an ICD-9-CM code, she says. "They're mandated [by HCFA] to give us a diagnosis, but not mandated to give us the code."

If the scheduler gets only a description, not the actual ICD-9-CM code, Miller notes, she can enter the description and a group of diagnoses will appear with the ICD-9-CM codes. If the proper diagnosis can be identified easily, the scheduler selects it. Otherwise, the patient will be asked to sign an advance beneficiary notice (ABN) form **(See copy of form, p. 125)**, assuming responsibility for the cost if Medicare will not cover it, she adds.

If the physician's office does supply an ICD-9-CM code, the scheduler types it in, along with the CPT-4 code, and either a smiling face or a frowning one appears on the screen, depending on whether the two match, Miller says. If the response is positive, the information goes through the computer system and is recorded on the patient registration.

Ultimately, the information is picked up by the medical records staff, which codes the account using the initial ICD-9-CM code and perhaps a code for the test results, she points out. "As long as we have the initial [code] that supports [the procedure], we know we'll get paid."

Over the past year, Miller adds, she's had many arguments with medical records personnel about whether that initial code is required, she says. "Our local Medicare intermediary published something that made it clear to use both [codes], and I keep it next to me all day long. It has made my argument so much easier."

Any access department that implements this kind of procedure "will have trouble with the medical records department," she predicts. "You've just got to keep working with them and make sure they're coding from the results *and* from the initial admitting diagnosis or symptom."

The response she often receives from medical records employees, Miller says, is, "I can only code what I see," which means the results of the test as reported in the medical record. But this attitude, she points out, can result in the hospital not being reimbursed for what are, in fact, allowable procedures.

A physician might order, as in one actual BHS case, a computerized axial tomography (CT) scan of the head, and in the notes mention that the patient had surgery a couple of months before. "There is a diagnosis — V15.2, personal history of surgery to a major organ — that makes the CT allowable under Medicare," Miller explains. "If [medical records personnel] had known that, they could have coded it." In that case, the code wasn't included, and the hospital didn't get reimbursed for the procedure, she adds. "Even after I showed them, they still wanted to argue with me."

She suggests encouraging medical records personnel to become familiar with local medical review policy bulletins, generally issued monthly by Medicare intermediaries to inform providers of updates or additions to medical necessity rules.

"Be a step ahead," Miller advises. "Know what Medicare wants, what it considers allowable, and if it's there, use it. If you catch it after the fact, your only opportunity is to rebill, and with 10 hospitals, we're just not able to handle the volume."

If the scheduler gets a negative response when the diagnosis and procedure codes are entered, "we have to be careful how we invite a further diagnosis from the physician," she says. "We don't want to sound like, 'We won't be paid for this diagnosis; you have to give us something else.'"

Instead, Miller adds, the scheduler will say, "This diagnosis doesn't support medical necessity. Perhaps there's another diagnosis you failed to get." The physician's office employee then may review the record or talk to the physician, she says. "Maybe they had a whole slew of diagnoses and just didn't give them to us."

If this effort still doesn't result in a successful match, the hospital scheduler faxes the physician's office the ABN form, with the patient's name, the test, and why the patient is being asked to sign, Miller says.

At this point, the physician may decide to take another route or may say, "I think you really need this test, but Medicare may not pay," Miller says. "The ultimate outcome is the physician and the patient talking together, making that decision. It gets the physician involved in the whole medical necessity kick. Many of them feel, 'It's not my problem, it's the hospital's,' but if you read [the directives] from HCFA, the intention is that it is the doctor's problem."

Determining medical necessity in advance is also a customer service issue, explains **Sandra Holmes,** RN, BSN, clinical revenue specialist for the BHS consolidated business office. "It's very aggravating for the patient or the family to take off work, park, come in, and find out that the diagnosis may not support this procedure.

"People would rather know upfront," she says, "so they can call the physician and ask, 'Why is this test necessary?' It's getting the patients more involved with the physicians and with their own health care." ■

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Health system gives physicians coding 'bible'

Baptist Health System (BHS) in Birmingham, AL, made little progress in its efforts to check procedures in advance for medical necessity until it offered physicians a guidebook, says **Becky Miller**, director for compliance, patient business services. *Code First: Medicare Medical Necessity Reference* lists the procedures for which the Baltimore-based Health Care Financing Administration (HCFA) requires that medical necessity be shown and the diagnoses codes (ICD-9-CMs), with their descriptions, that support each procedure, she adds. **(See excerpt, p. 124.)**

Although Alabama's Medicare intermediary, as is true in other states, issues monthly bulletins called LMRPs (local medical review policies) that notify providers of tests for which medical necessity must be shown, those bulletins "don't give full descriptions, just codes," Miller points out.

Developed at hospital

Code First is the brainchild of David Alligood, a finance department employee at Cullman (AL) Regional Medical Center, one of 10 BHS hospitals. Alligood worked with the hospital's medical records director and Miller to compile the guide, and Cullman's chief financial officer "pushed the buttons" to make it a reality, Miller says. Since mid-July, BHS has distributed some 1,500 guides to physicians, who "really like them," she says. "We've gotten good feedback. We really made little progress until we came up with this as a tool."

Because HCFA continually modifies and adds to the medical necessity guidelines, the book "was only good for one month," she says, and updates must be distributed each time an LMPR bulletin is received. To promote use of the guide, BHS has set up meetings and hosted breakfasts and luncheons for physicians and their staffs, she notes.

The Montgomery-based Alabama Hospital Association has approached Cullman Regional Medical Center officials about possibly endorsing the guide for more widespread use, notes **Sandra Holmes,** RN, BSN, clinical revenue specialist for the BHS consolidated business office.

Part of her role in the medical necessity effort, she says, is to emphasize the significance of those Medicare regulations to physicians and their

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CodeFirst™ Medicare Medical Necessity Reference

Procedure: Abdominal Ultrasound

EXCERPT

Source: Medicare Focus - March/April 1998
Revisions: Medicare Focus - May 1999

CPT/HCPCS	Description
76700	Echography, abdominal, B-scan and/or real time with image documentation; complete
76705	Echography, abdominal, B-scan and/or real time with image documentation; limited (eg, single organ, quadrant, follow-up)

The following **ICD-9 Codes** support medical necessity for the procedures listed above:

ICD-9	Description
Diseases of Other Endocrine Glands	
250.40	NIDDM/NOS Diabetes Controlled w Renal Manifestation
250.41	IDDM Controlled w Renal Manifestation
250.42	NIDDM/NOS Diabetes Uncontrolled w Renal Manifestation
250.43	IDDM Uncontrolled w Renal Manifestation
Diseases of Arteries, Arterioles, and Capillaries	
442.1	Aneurysm of Renal Artery
Other Diseases of Digestive System	
571.5	Cirrhosis of Liver w/o Alcohol
571.8	Chronic Nonalcoholic Liver Disease NEC
573.8	Liver Disorder NEC
573.9	Liver Disorder NOS
574.00	Cholelithiasis w Ac Cholecystitis w/o Obstruct
574.01	Cholelithiasis w Ac Cholecystitis w Obstruct
574.10	Cholelithiasis w Cholecystitis NEC w/o Obstruct
574.11	Cholelithiasis w Cholecystitis NEC w Obstruct
574.20	Cholelithiasis w/o Cholecystitis w/o Obstruct
574.21	Cholelithiasis w/o Cholecystitis w Obstruct
574.30	Choledocolithiasis w Ac Cholecyst w/o Obstruct
574.31	Choledocolithiasis w Ac Cholecyst w Obstruct
574.40	Choledocolithiasis w Cholecyst NOS w/o Obstruct
574.41	Choledocolithiasis w Cholecyst NOS w Obstruct
574.50	Choledocolithiasis w/o Obstruction
574.51	Choledocolithiasis w Obstruction
574.60	Calculus Gallbladder/Bile Duct w Ac Cholecyst
574.61	Calculus Gallbladder/Bile Duct w Ac Cholecyst

Dear Patient;

Patient Name _____ Date of Birth _____ Medicare# _____ Physician _____

Your physician may order a test(s) to be performed which he/she believes to be relevant to evaluate, monitor and protect your health. However, Medicare will only pay for services which it determines to be 'reasonable and necessary'. If Medicare determines that a particular test or service is not 'reasonable and necessary' under Medicare standards, then Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for the test(s) listed below for the following reasons:

CPT/HPCPS **Procedure:**

Reason for Denial:
Medicare may not pay for this test(s) for persons with your diagnosis, or no diagnosis.

Beneficiary Agreement to Pay

The effect of signing this 'Agreement to Pay' is that you **will** receive the item or service, and you most likely will be personally responsible for payment to your physician or healthcare provider.

I have been notified by my physician or healthcare provider that he/she believes, in my case, Medicare is likely to deny payment for the services identified above for the reason stated. I understand that I have the right to decide whether or not to receive the test or services identified above. I have decided to receive the test(s), if Medicare denies payment. I agree to be personally and fully responsible for the payment.

X
Patient Signature _____ Date _____ Witness Signature _____ Date _____

Initial here if you want us to bill Medicare for services services excluded from coverage and obtain a denial statement. _____ Witness Signature _____

Beneficiary Refusal to Receive Service at Own Expense

The effect of signing this 'Refusal' is that you will **not** receive the test or service(s).

I have been notified by my physician or healthcare provider that he/she believes, in my case Medicare, is likely to deny payment for the services identified above for the reason stated. I understand that I have the right to decide whether or not to receive the test or services identified above. I have decided not to receive the service since I am not willing to be personally responsible for payment.

Patient Signature _____ Date _____ Witness Signature _____ Date _____

CAUTION: Medicare Benificiary - Do Not Sign Blank ABN Forms

1. *Do not sign the Agreement to pay on this ABN **unless** the notice above both; a) specifies the test or service that may be denied, and b) specifies the reason it may be denied.*
2. *Sign and date either the 'Beneficiary Agreement to Pay' or 'Beneficiary Refusal to Receive Service at Own Expense'. **If you refuse to sign either one, and still demand to receive the service(s), you will be personally and fully responsible for payment.***
3. *By 'personally and fully responsible for payment' we mean that you will either pay out-of-pocket or by any other insurance coverage that you may have.*
4. *Your healthcare provider should give you a copy of this completed ABN form, please initial here _____ to indicate you have received a copy of this ABN.*

Advance Beneficiary Notice (ABN)

Source: Baptist Health System, Birmingham, AL.

(Continued from page 123)

office staffs, as well as to hospital personnel.

"I explain what we're trying to do, that this is required by federal law, and from the clinical side, interpret some of the diagnoses and concerns, Holmes adds. "I train [hospital] personnel on how to input the information into our computer system to check the diagnosis and how to ask if another diagnosis is appropriate. They can offer assistance, but it is against the law to tell the physician what code to use."

Sometimes matching diagnosis to procedure becomes a matter of semantics, she says. "Some of the physicians were ordering bone density studies, and the diagnosis was 'post-menopausal.' That diagnosis Medicare doesn't cover. 'Ovarian failure' is the diagnosis we must have. Well, what is menopause but 'ovarian failure'?"

In other instances, BHS has asked for clarification of contradictory or illogical medical necessity rules, Holmes says. For example, she adds, the diagnosis of "long-term headache" is acceptable justification for a computerized axial tomography (CT) scan if it is made in the emergency department, but not if it is made in a physician's office.

"We haven't received an answer yet, so right now we have to follow the Medicare [guidelines]," she says. "We ask the physician if there are other symptoms, another reason [for the CT scan]. We ask them to think it through, what they are looking for."

Holmes designed an advance beneficiary notice (ABN) form **(see p. 125)** that — under the new BHS policy — must accompany the order for any lab test that may not meet medical necessity, she says. The forms will be available at physician offices, as well as for use by home health nurses who may draw blood from patients in their homes, Holmes adds. "Patients have the right to refuse to have the test done or can agree to pay if Medicare doesn't cover it."

Some health care providers, in their zeal to ensure reimbursement, are having patients sign ABNs across the board, Miller points out. This "blanket" signing of waivers is not only illegal, she says, it gives the patient a false sense of security.

Those hospitals "are asking patients to sign the same form they signed the week before, and maybe that time the test was covered," she adds. "When you slap [the form] down routinely, they think it's just another piece of paper, but the whole point is to alert them. You are to get the waiver signed only if you suspect the test may not be paid." ■

It's quantity *and* quality for best documentation

Study OIG guidelines, expert advises

Here's a tip for access managers looking to improve their department's compliance IQ: Broaden your definition of documentation.

That's advice from **Michael T. Myers Jr.,** MD, MBA, director of health compliance strategies for PricewaterhouseCoopers in Boston, who emphasizes that "the bottom line is that documentation is more than the medical record."

Beyond the medical record and the CPT-4 code for "evaluation and management services," which is used to capture a lot of physician services, is "anything the physician or provider puts a pen to," Myers says. "There is a qualitative expectation of what good documentation is — that it is legible, fact-specific, chronologically ordered, with no obvious alterations. If there is any alteration, it generally should be initialed and dated."

OIG manual can help

Those kinds of qualitative documentation issues, Myers points out, are reviewed in the Office of the Inspector General's *OIG Program Guidance for Third-party Medical Billing Companies,* a reference manual he recommends for anyone concerned with accurate billing.

"Quantitatively, when it comes to documentation, we're talking about not only the medical record that needs to be logical and time-ordered, but also prescriptions, requisitions, advance beneficiary notices, any claims for billing, submission forms, and certification of medical necessity," he says. "Those are examples of other pieces of paper that OIG requires."

Most access managers, Myers suggests, are familiar with poor documentation, which is more often the rule than the exception. "Typically, what happens is that notes and orders and certification are illegible. What definitely should cause a red flag are if notes are scribbled, or intentionally altered, or there is missing information. You know the service was performed, but when you go through the record, you don't find anything."

For example, a physician might care for a hospital patient over a period of time that includes a holiday or a weekend, Myers notes. "Billing may happen on the inpatient side, and [the biller] will

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assume the physician took daily care of the patient from admission to discharge. In fact, there were probably a few days where the physician did not directly provide service. That's the most egregious example."

What access managers need to do, he advises, is understand that "there are definite expectations that have been voiced about what good documentation is" and then to meet those expectations. ■

Inflating length of stay may be risky business

Be careful with transfer DRGs, experts say

One year after the Health Care Financing Administration (HCFA) in Baltimore implemented its controversial transfer payment policy, some hospitals are compensating for lost revenues by inflating lengths of stay for the 10 affected diagnosis-related groups (DRGs).

Access managers with discharge responsibilities or who are involved in continuing stay reviews would do well to alert their institutions that HCFA may look with disfavor on such practices, experts advise. Those hospitals are walking a fine line between good business practice and what federal investigators might construe as outright fraud against the Medicare system, says **Deborah Hale**, president of Administrative Consultant Services in Shawnee, OK.

"When HCFA changed the transfer definition, it said that it would monitor hospitals' response to this ruling," she says. "My interpretation is, if you deliberately start holding your patients longer to capture the full DRG — if you change your practice for financial reasons — then that might be considered an inappropriate practice."

Until Oct. 1, 1998, a discharge from a prospective payment system (PPS) hospital was paid at the full DRG rate unless the patient was transferred to another PPS hospital. Under the new rule, which affects 10 specific DRGs, HCFA pays hospitals "transfer payments" rather than full DRG payments for patients discharged to post-acute care more than a day earlier than a national "geometric mean" length of stay defined by HCFA. That means hospitals with lengths of stay significantly lower than HCFA's geometric mean are penalized with lower reimbursement than that received by hospitals with greater lengths of stay.

In a financial impact analysis completed before the rule took effect last year, the Congressional Budget Office estimated the transfer payment policy would create overall hospital losses of around $100 million per year. Estimates from the American Hospital Association in Chicago range from $410 million to $450 million per year.

When it instituted the policy, the government claimed the transfer payment rules were established to prevent the illegal practice of "double-dipping," which HCFA defines as "submitting duplicate payments for care provided during a patient's episode of care."

But some experts have interpreted the new rule as simply an attempt by HCFA to reduce the level of Medicare reimbursement being paid for the 10 DRGs in question. "HCFA would rather pay a lesser amount to a skilled nursing facility than the per diem rate for the DRG," Hale says. "They would prefer to let hospital practice stay the way it is, with lengths of stay shorter than the geometric mean, and pay the lesser amount." That's why increasing lengths of stay to achieve full DRG payment could be risky for hospitals.

The potential dangers haven't dissuaded everyone, she says. "I am aware of some hospitals deliberately holding their patients in these 10 DRGs longer than they did in the past. I know of one that miscalculated and is holding patients even two days longer than it would have to [to achieve the full DRG]. Others have determined that they will keep patients until they stay one day less than the geometric mean so they can capture the full DRG. I think that's a risky decision."

At St. John's Medical Center in Tulsa, OK, case managers aren't keeping patients longer as a result of the transfer rule, but reducing length of stay for the 10 affected DRGs hasn't been a high priority, either, says **Joyce George**, RN, director of medical information management at St. John's. "We definitely haven't tried to push those patients hard," she says. "Some probably could have been transferred earlier, but I wouldn't transfer them because of the new rule."

In general, the transfer rule hasn't hit St. John's too hard, largely because lengths of stay there were never particularly low for the DRGs in question. "A lot of hospitals were transferring their total joint patients at three days," George says. "We had really not gotten to that point. Our numbers were close to the geometric mean. Our goal became to make sure that we kept them to the geometric mean more or less, rather than shortening the length of stay. Because they already kind of fell in line, it wasn't that much of a big deal. We just talked to the medical staff about it, told them why the rules were there and why we were doing what we were doing."

One reason the transfer rule hasn't posed much of a problem at St. John's is that for many of the affected DRGs, discharge planners have had difficulty discharging patients as quickly as they would like. "We try to get these patients into the level of care that's appropriate for them, but sometimes those beds are just not available, so we have to leave them in acute care. We've never been really tight on those DRGs."

For other hospitals, the transfer payment policy has complicated the discharge planning process, especially when nursing homes aren't on the same page as the hospital, Hale says. Indeed, some case managers have transferred patients to nursing homes as intermediate care patients, only to find later that the nursing home admitted the patient to a skilled bed. "The hospital didn't know about it, and, consequently, they billed their discharge to intermediate care rather than skilled care, which is subject to the transfer definition." Such costly mix-ups have been "the biggest hassle" for many hospitals in dealing with the transfer rule, Hale says.

While patient placement hasn't been a big problem at Elkhart (IN) General Hospital, the transfer payment policy has affected the hospital's bottom line, says **Shelby Morse**, RN, hospital director of case management. "Our finance department analyzed some of the numbers, and it looks to be between $150,000 and $200,000 in lost revenue," with most of the losses due to DRG 209 (major joint limb reattachment procedures of lower extremity, or total joint replacement), she says.

Even so, case managers at Elkhart haven't made any adjustments to compensate for the lost revenue. Indeed, lengths of stay for DRG 014 (specific cerebrovascular disorders except transient ischemic attack) actually have fallen by almost half a day since the transfer rule took effect.

"Most of our stroke patients are going to inpatient rehabilitation here, so there's still revenue," Morse says. "Even though we're getting a smaller DRG payment, we're still getting revenue. We're not hanging around waiting and prolonging patients' overall length of stay just to get one more day of DRG payment."

Good PR offsets financial losses

Similarly, although the hospital has lost money with regard to DRG 209, no changes have been made to Elkhart's popular and successful total joint replacement program. "There's a lot of positive public recognition of that program, as well as positive patient impact," Morse says.

"We're not going to change that, because we're getting good PR from it. So even though there is some bottom-line impact, at this point it's not affected us enough for us to really rethink the way we're doing things." That could change, however, if HCFA decides to expand the number of DRGs included under the transfer rule, Morse notes.

Similarly, case managers at the University of Pennsylvania Medical Center in Philadelphia decided to make no adjustments regarding the transfer payment policy, despite lost revenue. "We have clinical pathways in which length of stay is shorter than the transfer rules' length of stay," says **Maryellen Reilly**, MS, MT, director of clinical resource management and social work. "But we felt that what we were doing was best practice, so we stayed with it, even though we knew it would impact reimbursement."

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Hale suggests that the best approach for access managers eager to offset reimbursement losses due to the transfer payment policy is to focus their energy on reducing costs and lengths of stay for patients with complicated conditions. "Really focus on the complex patients who stay in the hospital eight, 10, or 12 days and generate cost savings there rather than trying to save one day here or there for everyone else." ■

Automated dialing speeds preadmissions

It's not just for collections anymore

Call management systems, long used by hospital collection departments to urge patients to pay up, are gaining acceptance on the other side of access: facilitating preadmission and preregistration.

The admissions/registration department at the University of California at San Francisco (UCSF) Stanford Healthcare, adjusting to severe staff reductions, is increasing productivity through its use of the Unisom System, a predictive dialer from Davox Corp. in Acton, MA, according to **Rosana Leon,** systems specialist for registration information systems.

Formal statistics are not yet compiled, she says, who is project manager and system administrator for the predictive dialer, but employees say it allows them to complete about eight preadmissions per hour, compared to four or five with manual dialing.

The system enables callers to avoid idle time, so they are constantly on the telephone, adds **Rogel Reyes,** supervisor for preadmissions and insurance verification. "It weeds out busy signals, sittones [automatic messages indicating a call won't go through], and answering machines."

The predictive dialer is one of the ways UCSF Stanford is dealing with reductions in staff that have resulted in two people making the preadmit calls formerly handled by six employees, Reyes says.

Rather than having employees work from a paper report to dial numbers, the list of patients to be preadmitted is downloaded to the Davox server, Leon explains. "[The preadmitting employee] logs in, and the system starts dialing phone numbers. The goal is [for the dialer] to predict the disposition of a call before it passes it on."

The system can be programmed to leave a message on an answering machine, she adds, such as, "Hello, this is UCSF Stanford Healthcare calling with regard to your scheduled appointment. We would like to preregister you prior to your arrival. Please call this number."

Callers who make contact with a real person, but not the right person, can program the dialer to call back when that person is expected to be available, Reyes notes. "It will pop up again on the admitter's screen as a recall, so [the employee] can say, 'I called earlier and am wondering if Mr. Jones is available now.'"

Meanwhile, he adds, the system can be used to track how many minutes an employee spends on an average call, how many minutes are idle, how many calls are a "true connect," how many busy signals the caller came across, and how many messages the dialer left when it detected answering machines.

Each of UCSF Stanford's two campuses has its own predictive dialer, Leon explains. The system used at the north campus, purchased some five years ago, originally was used for collections. A new system was purchased for the south campus, at a total cost — for equipment, server, application, and development — of about $250,000, she says.

The only "glitch" she recalls experiencing with the dialer had to do with its purported ability to call directory assistance if it reaches a wrong number, Leon notes. The caller is supposed to be alerted that the system has reached a "no longer in service" message and then be able to press a key that would activate the directory assistance feature. The problem with that feature is still being worked out, she adds.

After some initial resistance to the newly automated method of preadmitting, staff have welcomed the change, Leon says. "One person actually told me, 'I could never imagine myself going back to the old way.'" ■

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'Scripting' software saves system big bucks

Solution found on the Web

Access managers despairing about their perceived inability to change things — and perhaps being held captive by outdated software — may take heart from this story of "thinking outside the box."

ScrippsHealth in San Diego was faced with a seemingly insurmountable obstacle, says **Leonard Womack,** CPC-H, manager of revenue management, about 18 months into the process of consolidating the chargemasters for the system's six hospitals into a uniform numbering system.

"We were under the impression that our information services [IS] vendor was going to take the file, which had been created in Microsoft Excel, and then upload it into our system, which [the vendor] has done in the past on a smaller scale," Womack says. "However, when we brought it to their attention that we would hand over the information in early September to be done by Oct. 1, they informed us that their resources were too thin."

Instead, the vendor proposed scheduling the activity in February or March, he adds, a time frame that was not acceptable. Doing the task manually, Womack estimates, would have taken about one year for each of the six hospitals.

Faced with the daunting task of keying in some 17,000 lines of charge code, with 60 or 70 keystrokes per code, Womack got quotes on services and consultants and came up with a budget of $38,000 for the project. The solution was less than satisfactory, he says, because of both the hefty price tag and the likelihood that there would be errors to correct, as with most repetitive keystroke tasks.

"It looked as though after a year and a half of hard work, the project couldn't be done," Womack says, "but it seemed to me that the transfer of data from one program to another should be able to be done in an automated fashion."

With that in mind, he began searching the World Wide Web, using "macro" as the key word, Womack adds. "As I looked at the hits, I realized that was not the word I was looking for, but I found the term 'scripting.' I searched there and found a couple of things, one of which finally worked out." The software he downloaded to provide the solution is called WinTask, he notes, and was developed by an independent software engineer in a village outside Paris. The program — a keyboard emulation tool — plays the role of a data entry employee, Womack explains, and types perfectly at a rate of 6,000 characters per minute.

Thirty-five additional uses for WinTask, which costs $400, have been identified, he says. The IS vendor originally slated to do the chargemaster work had planned to charge $5,000 per hospital for the upload, Womack adds.

By directing the software to a file of accounts to be rebilled, one person completed 5,000 rebills by lunchtime, he says. Normally, one biller can do about 50 rebills a day, so productivity for that job went from an expected 25 rebills per half day to 5,000. ■

Need More Information?

Leonard Womack, Revenue Management, ScrippsHealth, 10150 Sorrento Valley Road, #223, San Diego, CA 92121. E-mail: lwomack@scrippshealth.org.

ACCESS FEEDBACK

Should access reps meet a higher standard?

Martine Saber, CHAM, director of patient access services for Baycare Health System in Clearwater, FL, would like to know of any health care organizations that are requiring their access representatives to be certified or have associate or bachelor's degrees.

Saber says she has designed a "career ladder" for her employees that will compensate them according to education, certification, and skill level and is eager to hear what strides other hospitals have made in this direction.

"You get what you pay for," she says, with higher skill levels and higher pay resulting in more professionalism and productivity. "What I'm promoting is making my access services employees more professional by requiring that they be certified either with the new NAHAM [National Association for Healthcare Access

Management] technical certification **[see story, at right]** or the CPAT [certified patient accounting technician] certification from AAHAM [American Association of Healthcare Administrative Management]."

After looking at the material included in the new NAHAM examination, Saber notes, she will decide if both certifications are needed. "CPAT is focused on the business office and collections," she adds, "and is lacking on the clinical side — bed control and assignment."

[Editor's note: If you have feedback for Saber, please call editor Lila Moore at (520) 299-8730 or send e-mail responses to lilamoore@mindspring.com. Saber may be reached at Morton Plant Hospital, 323 Jeffords St., MS #43, Clearwater, FL. Telephone: (727) 462-7139. Fax: (727) 461-8488.] ▼

Try dress code survey, consultant suggests

Health care consultant **Gregg Johnson** responded by e-mail to the ongoing debate on the appropriate attire for access employees, last mentioned in the June 1999 *Hospital Access Management*.

"I am surprised that the customers aren't asked what they expect and want," says Johnson, who declined to identify his company affiliation. "This type of survey, if designed and administered appropriately, will likely end the debate at most institutions. The choice then becomes, 'Do we want to impose the policy?'"

Any hospital trying to decide what its dress code should be should conduct a survey of its own customers (patients, physicians, visitors, and fellow employees) and find out what is expected in professional dress code, he suggests. "The adage, 'You work like you're dressed,' has always been accurate for nonmotivated employees and usually accurate for motivated ones," Johnson continues. "The bottom line in my opinion: It's hard to fly like an eagle unless you have eagle feathers."

[If you would like to offer feedback on this issue, or if you have another concern you'd like to see addressed in this column, please contact editor Hospital Access Management *Lila Moore at (520) 299-8730 or by e-mail at lilamoore@mindspring.com.]* ■

NEWS BRIEF

NAHAM announces new access credential

The National Association of Healthcare Access Management (NAHAM) in Washington, DC, is offering a new technical certification, the Certified Healthcare Access Associate (CHAA).

The certification, designed to recognize the professional competency of access services line staff, is the only nationally recognized certification of its kind, according to NAHAM president **Karen McKinley,** RN, CHAM. Now in the pilot stage, the certification will be available in January 2000.

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The CHAA examination, she notes, will include questions regarding:

- admissions and registration;
- billing, insurance, and financial information;
- patient rights and responsibilities;
- customer service;
- laws and regulations that affect patient access services;
- Joint Commission on the Accreditation of Healthcare Organizations requirements;
- Health Care Financing Administration regulations;
- computer skills;
- total quality management.

"The examination's content is dynamic, just as the demands and qualifications change in access services," says McKinley, senior director of system access for Penn State Geisinger Health System.

The exam costs $75, which includes a study guide that can serve as an ongoing reference tool, and multiple employees may be tested at the same time, she notes. Line staff taking the examination do not have to be NAHAM members, and there is no recertification. For access personnel at the management level, NAHAM offers the Certified Healthcare Access Manager (CHAM) certification.

[For more details, contact NAHAM at (202) 857-1125 or visit www.naham.org.] ■

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Access managers revitalized in dramatic turnaround

Push under way for more training, higher pay

In a dramatic turnaround from just a few years ago, the health care industry appears to be experiencing a resurgence of recruitment and opportunities for strong patient access managers.

Coupled with that trend is a focus by cutting-edge organizations on obtaining better educated, more highly skilled frontline access employees and paying them accordingly.

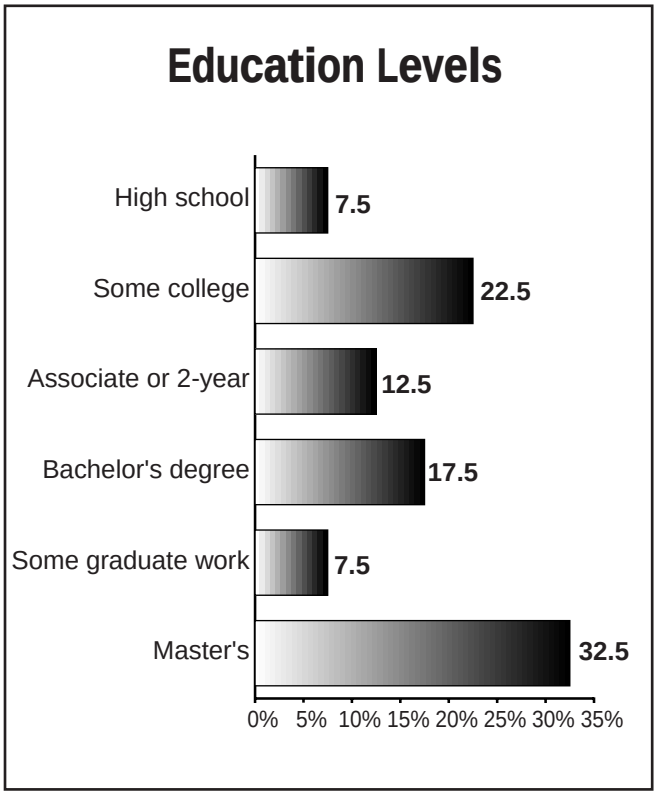
The profession continues to evolve and expand, according to leaders in the access field who talked with *Hospital Access Management* in connection with its annual salary survey report.

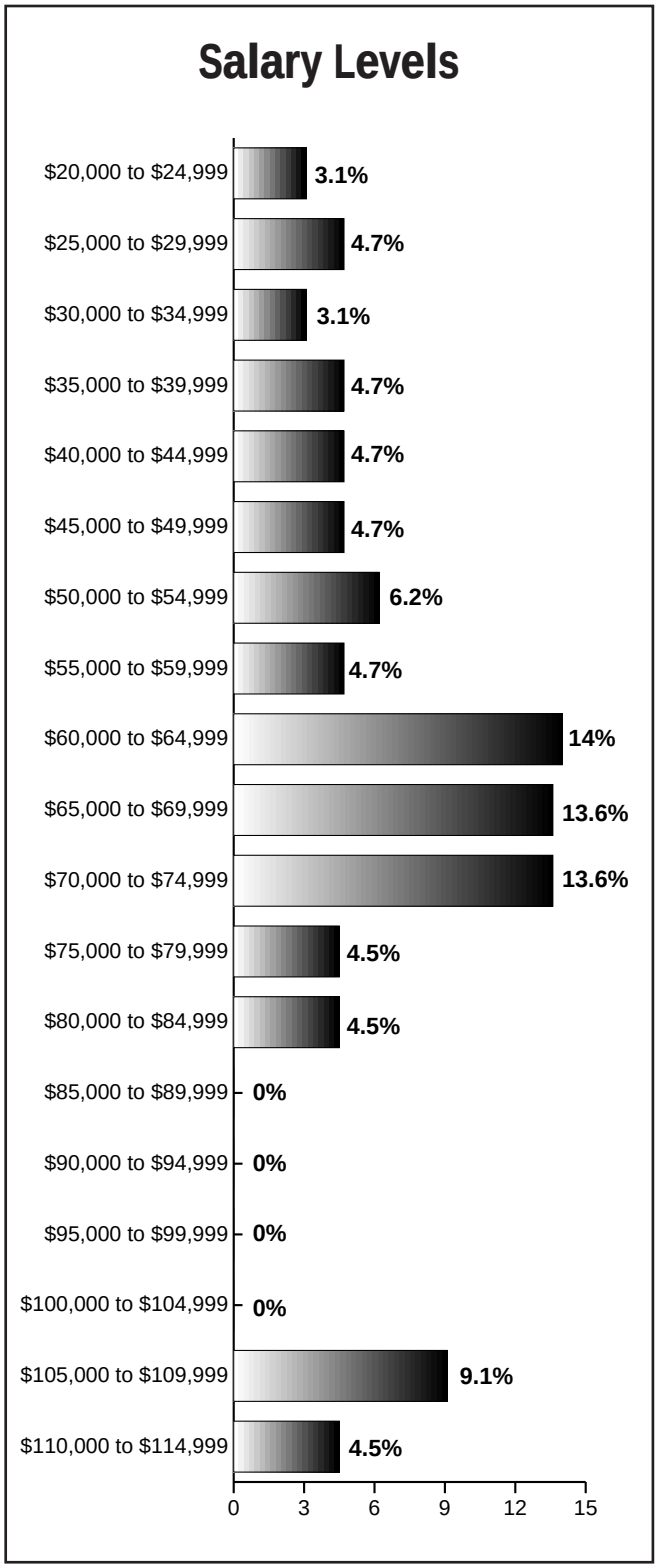
"It is increasingly difficult to recruit capable candidates who have the breadth of knowledge needed to manage increasingly complex operations," says **John Woerly,** RRA, MSA, CHAM, director of patient intake for St. Vincent Hospitals and Health Services in Indianapolis.

"Patient access is much more diverse than what appears to the naked eye," he adds. "It is a mixture of finance, health information services, patient relations, systems design, information services, management engineering, and clinical aspects. That is what makes it so exciting but, at the same time, a high burn-out profession."

Woerly says he has seen a growing level of recruitment for patient access management positions, noting that the market for all levels — including the associate level — has tightened in most areas of the country.

Perhaps in connection with that growing demand, the overwhelming majority of access managers and directors responding to the *Hospital Access Management* 1999 salary survey said they received raises in the past year. Just under 70% of the respondents reported salary increases of between 1% and 6%, but a fair number (12.8%) said their raises were between 7% and 10%.





The salaries of access managers and directors responding to the survey ran the gamut, from the low $20,000s to the low $100,000s, but the highest concentrations were between $60,000 and $75,000, which included a little more than 40% of respondents. Nearly half of respondents said the number of employees in their departments had increased in the past 12 months, and for most of the remainder — just under 40% — the number of employees remained the same.

Several leaders in the field told *Hospital Access Management* the beleaguered access manager of a few years ago has been revived, in some cases emerging stronger than before.

Charlene Overfield, RN, CHAM, a Tigard, OR-based consultant with Gustafson & Associates and former access manager, says she is seeing a reversal of the move toward eliminating access management positions that occurred when hospital mergers began.

"I'm from a part of the country where consolidation happened five or six years ago, and a lot of hospitals were coming together under a health care system that 'flattened out' management," Overfield adds. "They tried to have a director of access over the system, instead of a manager or director at each facility. A lot of that shake-up has been completed, and where access positions were lessened or eliminated, they have been put back into place."

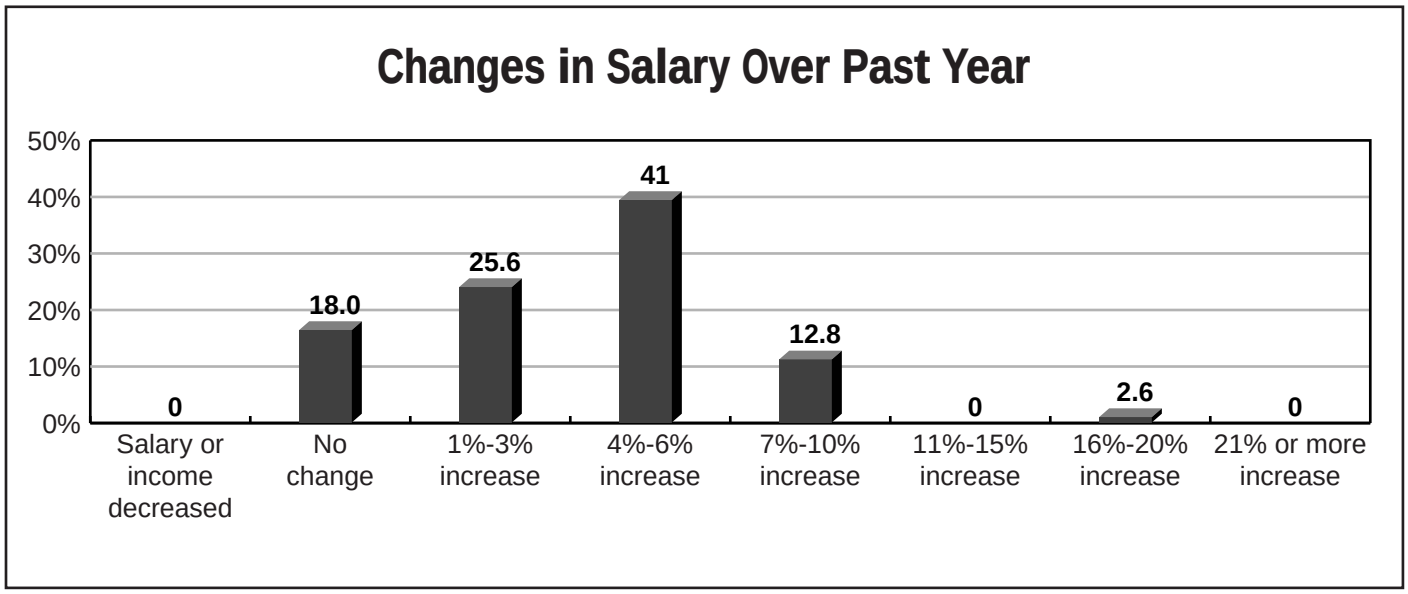
Because of the movement of insurance verification and other traditional business office functions to the point of service, access "has become more of a focal point," she notes. "Organizations realize they can't have a good bottom line unless they have a good front line."

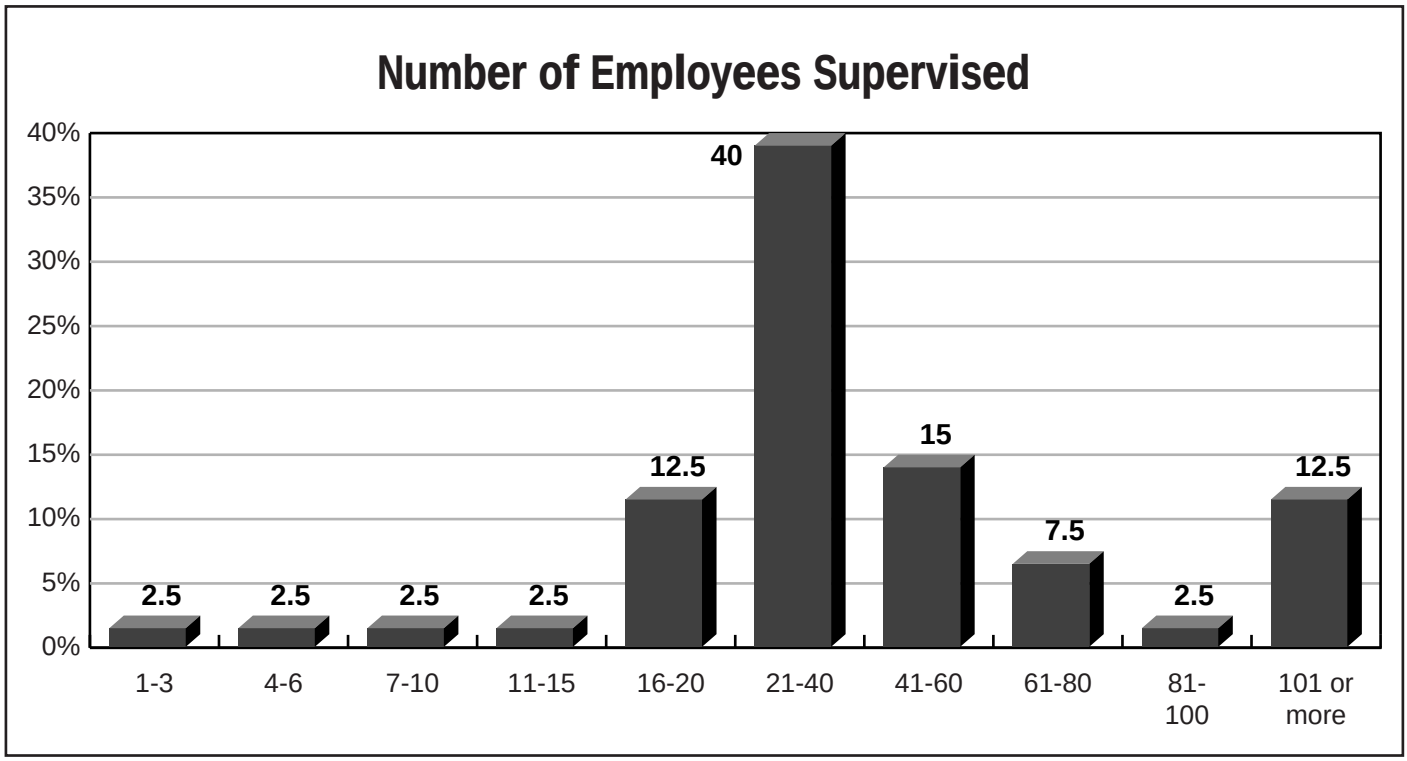
Bringing staff up to par

With that in mind, health care organizations are putting more resources into getting qualified managers and bringing the status of access staff up to par, she says. "Because there has been a lot of turnover, which is very costly, administration has realized they need to increase qualifications and increase salary scale, especially with today's low unemployment rate."

Through conversations with recruiters looking to fill access positions, Overfield notes, she has noticed an increase in the salaries being offered for access managers. While her observation has been that managers at a single facility may be paid between $50,000 and $70,000, she adds, that figure can jump significantly as responsibilities increase.

When a person goes from being an admitting manager to truly being an access manager or director, that should mean overseeing more than just registration activity, Overfield points out. In cases where, for example, utilization review, transportation, and other departments fall under an access professional's purview, she adds, "I have





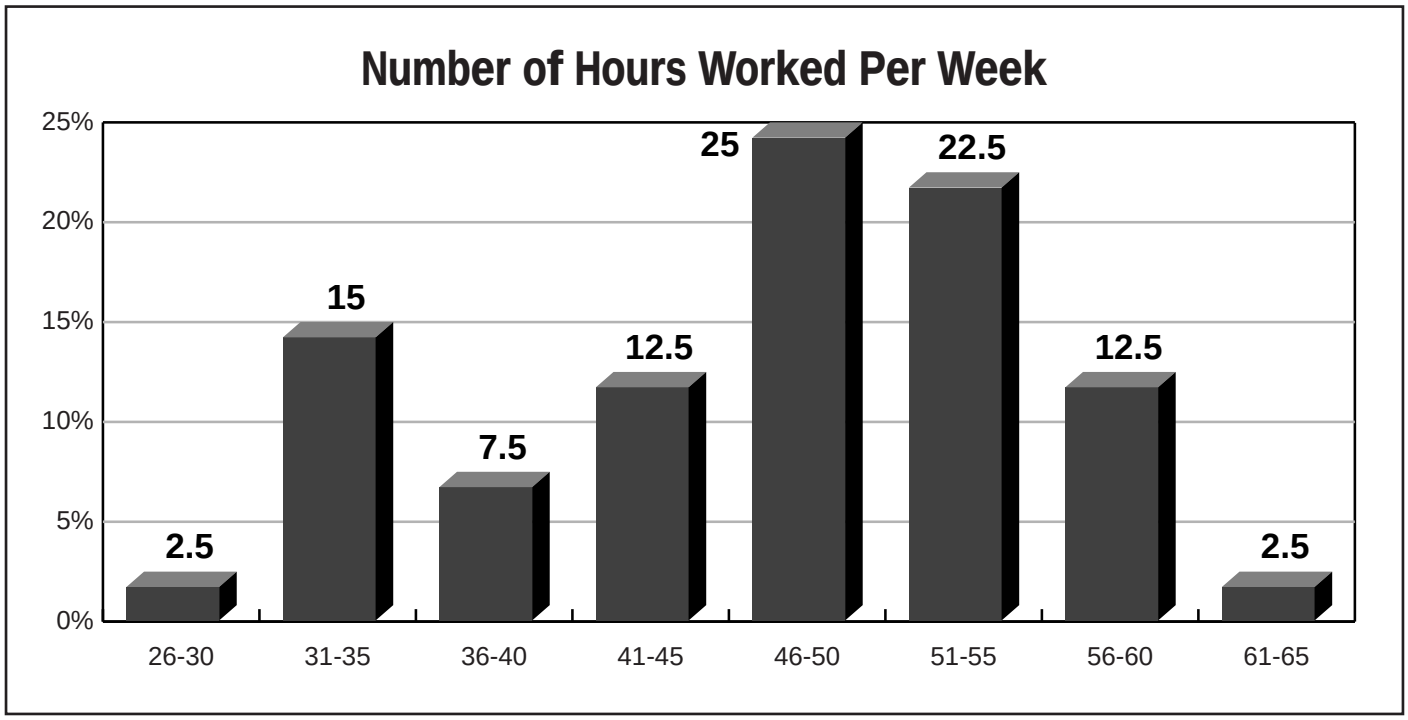
seen directors at single facilities with salaries in the six digits.

"The more [organizations] bring processes upfront that the business office used to have, like financial counseling and insurance verification, that gives the access director a lot more responsibility and also makes the salary higher," she says. Salaries for regional access directors typically range from "$80,000 to $100,000-plus," Overfield notes, "and the more consolidation they have, the higher the salary."

In line with their increased responsibility, many access directors are moving toward reporting to finance or to the chief financial officer of a hospital or health system, rather than to operations, says **Rosalind Conner**, director of patient access for Duke University Medical Center in Durham, NC.

"Our presence with respect to the financial stability of our organizations is key, as well as in meeting the many compliance demands," she adds. "Organizations have a better appreciation of our strengths and expertise, not only in the financial arena, but also in understanding the larger picture with regard to overall hospital/health system operations."

ScrippsHealth, a six-hospital system in San Diego, is offering its hospital access managers a



chance to move up the salary scale by adding enterprisewide responsibilities to their on-site duties, says **Jack Duffy**, FHFMA, corporate director of patient financial services.

"Our basic salary structure for access is from $41,000 to $61,000 for a single-unit manager, with the average salary at about $55,000," Duffy says. However, these on-site managers are now taking on responsibilities such as point-of-service collection management and training, which cover multiple sites, he adds. The range for access professionals with enterprise duties is $52,000 to $82,000, Duffy notes.

"Instead of their salary peaking in the $50,000s," he says, "these managers can now move into the $70,000s."

Recognition of the crucial role access now plays in a health system's financial health also is spreading to frontline employees, who traditionally have been paid lower salaries than their colleagues in the business office, says **Martine Saber,** CHAM, director of admitting for Baycare Health System in Clearwater, FL.

Saber has designed a career ladder for access representatives that will compensate employees based on education, certification, and skill level, she adds. The proposal, now under review by Baycare's president, has drawn praise from persons throughout the organization, Saber notes, including Baycare's patient business services directors.

"They see that it will promote professionalism," she adds. "The back end can no longer afford to clean up the mistakes of the front end."

Saber says she also has plans to require certification for frontline access employees, whether it be the certified patient accounts technician (CPAT) designation offered by the American Association of Healthcare Administrative Management, or the newly announced certified health care access associate (CHAA) credential being offered in January by the National Association of Healthcare Access Management.

"With certification, more professionalism at the front end, there is less clean-up at the back end," she adds. "There will be a new breed of frontline professionals." ■